Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Vincasar PFS
(vincristine)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Vincasar PFS 1mg/mL vial ☐ vincristine 1mg/mL vial
☐ Vincasar PFS 2mg/2mL vial ☐ vincristine 2mg/2mL vial

ICD10: Dose:
Frequency of therapy: Duration of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ acute lymphoblastic leukemia (ALL), including pediatric acute lymphoblastic leukemia
☐ adult T-cell leukemia/lymphoma (ATLL)
☐ AIDS-related B-cell lymphoma
☐ anaplastic glioma
☐ Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN)
☐ bone cancer including Ewing Sarcoma
☐ Burkitt lymphoma
☐ Castleman's disease (CD, giant lymph node hyperplasia, angiofollicular lymph node hyperplasia [AFH])
☐ chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
☐ diffuse large B-cell lymphoma (DLBCL)
☐ follicular lymphoma (FL)
☐ gastric MALT lymphoma
☐ Gestational Trophoblastic Neoplasia (GTN)
☐ glioblastoma
☐ Hepatosplenic Gamma-Delta T-Cell Lymphoma (HGDTCL)
☐ High-Grade B-Cell Lymphoma
☐ Merkel cell carcinoma (MCC)
☐ neuroendocrine tumors (NET) – pheochromocytoma (PCC)/paraganglioma
☐ nodal marginal zone lymphoma (NMZL)
☐ nongastric MALT lymphoma
☐ ovarian, fallopian tube, or primary peritoneal cancer
☐ peripheral T-cell lymphoma (PTCL)
☐ pilocytic astrocytoma
☐ post-transplant lymphoproliferative disorder (PTLD)
☐ primary CNS lymphoma
☐ primary cutaneous CD30+ T-cell lymphoproliferative disorder
☐ small cell lung cancer (SCLC)
☐ soft tissue sarcoma (STS) including rhabdomyosarcoma(RMS)
☐ splenic marginal zone lymphoma (SMZL)
☐ Squamous Cell Carinoma of the head and neck (SCCHN) including ethmoid sinus, maxillary sinus, very advanced
☐ supratentorial astrocytoma/oligodendroglioma
☐ T-cell lymphoma – breast implant-associated ALCL
☐ thymoma or thymic carcinoma

☐ Histologic Transformation of Marginal Zone lymphoma (MZL) to Diffuse Large B-Cell lymphoma (DLBCL) ☐ Hodgkin's lymphoma (HL) ☐ Mantle cell lymphoma (MCL) ☐ medulloblastoma	☐ Waldenström's macroglobulinemia (WM, lymphoplasmacytic lymphoma) ☐ Wilms' Tumor ☐ other (please specify):

Clinical Information:

(if DLBCL) Is the drug requested being given every 14 days with rituximab (Rituxan, Ruxience, Truxima), cyclophosphamide, doxorubicin (Hydroxydaunomycin), and prednisone (also known as R-CHOP-14 treatment or dose dense R-CHOP)?

☐ Yes ☐ No

(if PTCL) Is your patient using vincristine (Vincasar PFS) as a part of Hyper CVAD alternating with high-dose methotrexate (MTX) and cytarabine? Note: Hyper CVAD consists of hyperfractionated cyclophosphamide, vincristine [Vincasar PFS], doxorubicin [Adriamycin], and dexamethasone.

☐ Yes ☐ No

Additional Information: (*please include disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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